## DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES SERVICE PLAN

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Plan's Effective Date:/_ MM D	_/ Plan's End D	ate://_ MM DD YY	
Name	Address		Phone Number
Person:			( )-
Support Coordinator:			( )-
the support system and if appli	erly Case Management) serves the cable in the Home and Communit rt needs and (b) coordinating the	y-Based Waiver in accordance	with program requirements and
services, regardless of the f develop a personal budget b identify the supports necess. write and update personal so write, coordinate, integrate, ensure a person-centered pl provide ongoing monitoring provide an initial assessmen review the individual's supportion instruct the individual/legal of funding source, and provide discharge planning so to the waiver.	rts, state plan services, medical, s unding source, ased on the individual support pla ary to insure the individual's healt ocial history, and assure the implementation of	an, th and safety,  If the individual's support plan y of the supports identified in e individual's level of care dete lly, pendently obtain access to ser y prior to the date an individual	the individual's plan, ermination, vices and supports, regardless of
Expected//_ Start Date: MM DD YY	Intensity:	Qu	me/Title of Provider: alified Mental Retardation ofessional with State Division
Amount/Frequency:			
Duration:			
Medical			
Outcome: Please check all that  □ ensure person has the best p  □ other (please specify)	ossible health		
			<del></del>
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Duration:  Dental  Outcome: Please check all that apply: □ ensure person receives preventative and necessary dental care and check ups. □ other (please specify) □ their (please specify) □ Intensity:	Amount/Frequency:			
Outcome; Please check all that apply: ensure person receives preventative and necessary dental care and check ups. other (please specify)  Expected / // Intensity: Name/Title of Provider:  Expected / // Amount/Frequency:  Duration:  Day Support (site and non-site based day support or senior supports)  Outcome; Please check all that apply: facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation other (please specify)  Expected // Intensity: Name/Title of Provider:  Expected // MM DD YY Intensity: Name/Title of Provider:  Community Living Support (companion services, supported marriage for married couples, supported living, supervised living, host or professional parent home, etc.)  Outcome; Please check all that apply: facilitate independence and promote community integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person other (please specify)  Expected // MM DD YY Intensity: Name/Title of Provider:  Expected // MM DD YY Intensity: Name/Title of Provider:	<u>Duration:</u>			
Outcome; Please check all that apply: ensure person receives preventative and necessary dental care and check ups. other (please specify)  Expected / // Intensity: Name/Title of Provider:  Expected / // Amount/Frequency:  Duration:  Day Support (site and non-site based day support or senior supports)  Outcome; Please check all that apply: facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation other (please specify)  Expected // Intensity: Name/Title of Provider:  Expected // MM DD YY Intensity: Name/Title of Provider:  Community Living Support (companion services, supported marriage for married couples, supported living, supervised living, host or professional parent home, etc.)  Outcome; Please check all that apply: facilitate independence and promote community integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person other (please specify)  Expected // MM DD YY Intensity: Name/Title of Provider:  Expected // MM DD YY Intensity: Name/Title of Provider:				
ensure person receives preventative and necessary dental care and check ups.  □ other (please specify)  Expected / / / Start Date: MM DD YY  Intensity: Name/Title of Provider:  Day Support (site and non-site based day support or senior supports)  Outcome: Please check all that apply: □ provide structure, supervision, and meaningful activity for person with brain injury □ facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve □ provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation □ other (please specify)  Expected / / Intensity: Name/Title of Provider:  Expected / / MM DD YY  Intensity: Name/Title of Provider:  Community Living Support (companion services, supported marriage for married couples, supported living, supervised living, host or professional parent home, etc.)  Cutcome; Please check all that apply: □ reclinate inclusion of provider intensity integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person chooses. □ other (please specify)  Expected / / MM DD YY  Intensity: Name/Title of Provider:  Expected / / MM DD YY  Intensity: Name/Title of Provider:	Dental			
Start Date: MM DD YY	□ ensure person receives preventative and			
Duration:  Day Support (site and non-site based day support or senior supports)  Outcome; Please check all that apply: □ provide structure, supervision, and meaningful activity for person with brain injury □ facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve □ provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation □ other (please specify)  Expected/_/_ Buration:  Community Living Support (companion services, supported marriage for married couples, supported living, supervised living, host or professional parent home, etc.)  Outcome: Please check all that apply: □ facilitate independence and promote community integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person chooses. □ other (please specify)  Expected/_/_ Start Date; MM DD YY  Intensity:  Name/Title of Provider:	Expected/_/_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Day Support (site and non-site based day support or senior supports)  □ dutcome: Please check all that apply: □ rovide structure, supervision, and meaningful activity for person with brain injury □ facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve □ provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation □ other (please specify) □ social isolation □ other (please specify) □ thensity:    Name/Title of Provider:	Amount/Frequency:			
Outcome: Please check all that apply:    rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision in skills a person wishes to acquire, retain, or improve   provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation   other (please specify)   Expected	<u>Duration:</u>			
Outcome: Please check all that apply:    rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision, and meaningful activity for person with brain injury   rovide structure, supervision in skills a person wishes to acquire, retain, or improve   provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation   other (please specify)   Expected				
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Start Date: MM DD YY  Amount/Frequency:  Duration:  Community Living Support (companion services, supported marriage for married couples, supported living, supervised living, host or professional parent home, etc.)  Outcome: Please check all that apply:   facilitate independence and promote community integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person chooses.   other (please specify)	<ul> <li>provide structure, supervision, and meaningful activity for person with brain injury</li> <li>facilitate independence and community inclusion and contribution, maintain the person's physical and mental skills, provide instruction in skills a person wishes to acquire, retain, or improve</li> <li>provide support for older adult or person who has needs closely resembling an older adult to facilitate inclusion and prevent social isolation</li> </ul>			
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Start Date: MM DD YY  Amount/Frequency:	☐ facilitate independence and promote community integration by assisting the person to gain or maintain skills necessary to live alone or with roommates as independently as possible in the type of community-based housing arrangement the Person chooses.			
Start Date: MM DD YY  Amount/Frequency:				
		Intensity:	Name/Title of Provider:	
<u>Duration:</u>	Amount/Frequency:			
	<u>Duration:</u>			

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Mental Health			
Outcome: Please check all that apply:    Maintain or improve the person's mental health and overall functioning.   other (please specify)			
Expected/_/_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Transportation (bus pass, taxi or day or	community living support provider transport	ation)	
Outcome: Please check all that apply:  allow the person to access other supports necessary to live an inclusive community life other (please specify)			
Expected// Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
Duration:			
Personal Assistance			
Outcome: Please check all that apply:  □ Provide personal care and non-medical supportive services specific to the person's needs  □ other (please specify)			
Expected/_/_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
Duration:			
Personal Emergency Response System			
Outcome: Please check all that apply:  Allow the person who has the skills to live independently or with minimal support to summon assistance in an emergency by use of an electronic device. Payment shall include the rental, purchase, installation, removal, replacement and or repair of the system.  Outcome: Please check all that apply:  In the person who has the skills to live independently or with minimal support to summon assistance in an emergency by use of an electronic device. Payment shall include the rental, purchase, installation, removal, replacement and or repair of the system.			
Expected// Start Date: MM DD YY	Intensity:	Name/Title of Provider:	

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Amount/Frequency:			
Duration:			
and bidet adaptations and plumbing modif	ons (ramps, lifts/elevators, modifications/addications, turnaround space adaptations, wide vehicle adaptations, trained and certified car	ening of doorways/hallways, specialized	
Outcome: Please check all that apply:  — enable the person to effectively function in the home 's physical environment by adapting the home with equipment and/or physical improvement to the home or vehicle necessary to assure the health, welfare or safety of the person.  — improve the person's level of independent functioning.  — other (please specify)			
Expected// Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
<b>Chore and Homemaker</b> (heavy househoduties).	ld chores, snow removal, lawn care, carpet	care, cleaning, and general household	
Outcome:    maintain a clean, sanitary and safe living environment for the person   other (please specify)			
Expected// Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Work Support (supported employment)			
Outcome: Please check all that apply:  assist the person find, keep, or change, employment or to advance in employment  other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Latch-Key Support (before and after school or work day child care).			

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Outcome: Please check all that apply:  provide supervision for child who is not receiving community living support and whose parents are working  other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Respite Care (day and overnight supports	s).		
Outcome: Please check all that apply:  □ provide supervision and/or relief, on a short-term basis for those individuals who normally provide care in a home setting for person unable to care for self  □ other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
<b>Educational Supports</b> (specialized educated education and related services).	ation, personal tutoring, personal instructions	s and registration fees for generic	
Outcome: Please check all that apply:  □ provide individualized educational opportunities  □ other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Family Assistance and Support (in or o with a disability at home).	out of home assistance to keep family togethe	er and allow for parents to care for a child	
Outcome: Please check all that apply:  provide information and training about treatment, rehabilitative regimens and use of equipment necessary to safely maintain the person with a disability at home allow the child to remain and be supported in the family home provide leisure time activity and community inclusion for the child provide training, instruction, supervision to the family, caregiver, or child in all areas of daily living other (please specify)			

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Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Γ			
Specialized Supports (chiropractic thera	py, acupuncture, massage therapy, commur	nication support, counseling for siblings).	
Outcome: Please check all that apply:  provide treatment, training, consultation, or other unique services necessary to achieve improvement in physical/mental health provide training, consultation or treatment to facilitate communication or use of alternative communication strategies provide training, instruction, and counseling to siblings of a person with disability to improve or maintain the home unit and facilitate positive relations and family dynamic other (please specify)			
Expected/_/_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Brain Injury Homemaker Service (hou	sehold activities).		
Outcome: Please check all that apply:  provide meal preparation and routine household care for the person other (please specify)			
	I		
Expected// Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Brain Injury Companion Service (supervision and socialization services).			
Outcome: Please check all that apply:  □ provide a companion to assist the person in connecting with the community and to avoid isolation  □ provide assistance with meal preparation, laundry, shopping, etc.  □ other (please specify)			
Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			

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Brain Injury Counseling (conflict resolution/counseling for person and person s family).			
Outcome: Please check all that apply:  provide treatment, training, consultation, or other unique services necessary to achieve improvement in person's mental health provide training, consultation or treatment to facilitate communication of problem areas provide training, instruction, and counseling to improve or maintain the home unit and facilitate positive relations and family dynamic other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
	uation of the general health and wellness of al history for planning completed by a registe		
Outcome: Please check all that apply:  promote the person's health status and prevent unnecessary physical and functional deterioration other (please specify)			
Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
non-waiver Guardianship Supports (a for challenge to guardianship).	cquisition of and ongoing support for obtaini	ing/maintaining guardianship, or support	
Outcome: Please check all that apply:  □ assure the person's legal rights are appropriately promoted and protected  □ other (please specify)			
Expected/_/_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
<u>non-waiver</u> Supplemental Child Care (childcare costs associated with a child 12 years old or younger with a disability that includes training or extra compensation for the child care provider).			
Outcome: Please check all that apply:  promote care in a natural family like setting so that parents may work or attend school other (please specify)			

□ other (please specify)

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Expected/_/_	Intensity:	Name/Title of Provider:	
Start Date: MM DD YY			
Amount/Frequency:			
<u>Duration:</u>			
	<b>tion</b> (information and assistance in identifyir maintenance and repair planning, facilitation		
☐ assist the person to purchase his/her ow	affordable, long-term, personal housing in t n home	-	
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Assessment			
Outcome: Please check all that apply:  □ other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
Duration:			
Emergency Plan			
Outcome: Please check all that apply:  other (please specify)			
Expected//_ Start Date: MM DD YY	Intensity:	Name/Title of Provider:	
Amount/Frequency:			
<u>Duration:</u>			
Social/Recreation			
Outcome: Please check all that apply:			

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Expected//_ Start Date: MM DD YY	Intensity:		Name/Title of Provider:
Amount/Frequency:			
<u>Duration:</u>			
services and supports. The providers o also informed me of my rights according	f services and supports listed o g to Policy 1-1, Individual Right derstand that if I disagree with	n this plan repres s, and my right to	, as well as all available providers of these ent my choice. My support coordinator has a a hearing according to Policy 1-5, Notice of providers that I have a right to a hearing
Signatures	:		
Person:		Date:	
Support Coordinator:		Date:	
Person's Legal Representative:		_ Date:	
A. <u>NON-WAIVERED SERVICE NEE</u> INCOME SOURCE; MEDICAL; MEDICAL Additional components to allow use of t	SERVICES INSURANCE (MEDIC	CAL CARD); SOCIA	ELING/THERAPY; EMERGENCY PLAN; AL/RECREATION.
·	inis plan as a raining contered i	iuri.	
assessment of persons ability	6		
assessment of concerns and processing steps	riorities or person and ramily		
<ul><li>□ action steps</li><li>□ family responsibilities</li></ul>			
<ul><li>team member time lines and e</li></ul>	expectations		
□ dated signatures from all team			